LOUISIANA 4-H
YOUTH DEVELOPMENT

2025-2026
4-H MEDICAL/HEALTH FORM

IMPORTANT - PLEASE READ!

To All 4-H Families:

It is one of the highest priorities that 4-H protects and cares for our 4-H members and adults who are participating in 4-H events, activities, workshops, and trips. To make this possible , we need your help in completing this health form with the most current information and maintaining it on an annual 4-H Medical/Health form.

Louisiana 4-H acknowledges the attached form is lengthy; however, your health and safety are our top priority. If anything changes related to the health, well-being, or medication of the person named on the form, a new complete form is required. This ensures that the Louisiana 4-H and Youth Development Program has clear and precise medical directives during an emergency.

A new health form will need to be completed for each event.

Thank you for being our partner in protecting our youth and adults in Louisiana 4-H.

CONFIDENTIALITY POLICY

Respecting the privacy of our members, parents, volunteers, staff, and of Louisiana 4-H itself is a basic value. Personal information is confidential and should not be disclosed or discussed with anyone without permission or authorization from the individual and/or parent/guardian listed on this form unless the individual is involved in the care and supervision of the minor. Care shall also be taken to ensure that unauthorized individuals do not overhear any discussion of confidential information and that documents containing confidential information are not left in the open or inadvertently shared.

Employees and volunteers of LSU AgCenter may be exposed to information which is confidential and/or privileged and proprietary in nature. It is the policy of LSU AgCenter that such information must be kept confidential both during and after employment or volunteer service. Staff and volunteers, including board members, are expected to return materials containing privileged or confidential information at the time of separation from employment of expiration of service.

INSTRUCTIONS TO LCES AGENTS AND SUPPORT STAFF:

1. If any change occurs a NEW Medical/Health Form must be completed. NO EDITS OR CHANGES ARE ALLOWED TO A MEDICAL/HEALTH FORM. All medical forms (current and non-current) must be retained in the parish office.
2. For in-parish events, the original forms may be taken to the event as needed. For regional and/or state events, it is advised the parish office make the necessary copy of the medical/health form and send in a closed envelope with the agent and/or supervising chaperone.
3. All medical/health forms when not in use for an event, activity, or trip must reside in the parish office in a secure location and inaccessible to the general public.
4. Forms are NOT to be accepted via email, fax, or other electronically transmitted format. The Medical/Health form cannot be saved on any electronic device owned or manged by the LSU AgCenter.

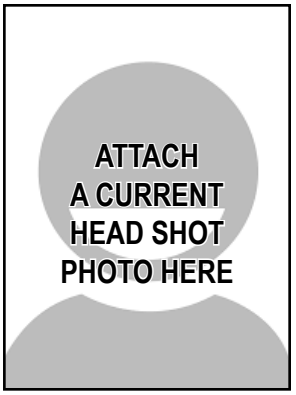
LOUISIANA 4-H YOUTH DEVELOPMENT

2025-2026 4-H MEDICAL/HEALTH FORM

(To be completed and signed prior to event. Participant MAY NOT participate without a health form.)

Event or Activity* _____

IF ANY INFORMATION CHANGES A NEW FORM MUST BE COMPLETED.



PARTICIPANT INFORMATION

Name of Participant _____ Date of Birth _____

First Middle Last Month/Day/Year

Address _____

Street/PO Box City State Zip Code

Cell Phone _____ Parish _____

PARENT/GUARDIAN'S INFORMATION FOR YOUTH

Parent/Guardian's Name _____

Phone Cell _____ Work _____ Home _____

EMERGENCY CONTACTS

	1st Emergency Contact	2nd Emergency Contact	3rd Emergency Contact
Name			
Relationship			
Home Phone			
Cell Phone			
Work Phone			
Email			

PARTICIPANT PICK UP (YOUTH ONLY)

Please list below individuals who are authorized to pick up or leave with your child. A photo I.D. may be required for these individuals to pick up or leave with your child. If additional pickups are needed please add a separate sheet containing the information below and attach it to this form.

	PERSON #1	PERSON #2
Name		
Relationship		
Cell Phone		
Driver's License #		

Youth will not be allowed to leave with anyone not authorized. Youth will not be released to individuals without permission from the parent or legal guardian. If based on the opinion of staff, the individual appears to be impaired, the child will not be released.

Please list any custody information we should be aware of on a separate sheet and attach it to this form.

SECTION 1: RESTRICTIONS

List any Dietary restrictions: ***(attach a page if extra space is needed for explanation)***

DISCLAIMER:
Information provided here does not guarantee the 4-H Program will provide special meals or needs.

Dietary modifications require a physician's written instructions to be given to 4-H staff two (2) weeks prior to the event.

Dietary request will not be honored for food preferences, personal taste, or for "picky eaters".

LSU AgCenter
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SECTION 2: VACCINATIONS

Are Immunizations Current _____ **Yes** _____ **No**

Vaccination Date

Tetanus (DTaP/DTP/Td)_____

Hepatitis B (Hep B - 3 Dose)_____

List any other Vaccinations_____

SECTION 3: CARE

Primary Physician Name _____

Primary Physician Phone _____

SECTION 4: REMARKS Please indicate **YES** or **NO** on each.

If yes, please explain below.		**YES**	**NO**
1	Does the individual have any health diagnosis that is important for staff to know in order to maximize participation and ensure safety and well-being?		
2	Does this individual have a learning disability, emotional or behavioral disorder and/or mental health diagnosis? If yes, please explain below.		
3	Does this individual have a physical disability?		
4	Any recent life events affecting participation?		
5	Other issues not already addressed?		

Explain any "Yes" items noting the number of the question. Please include any ways we can provide support and/or encouragement to assist them while participating. ***Include any instructions to assist in case of Emergency.***

(Attach a page if extra space is needed for explanation)

ATTENTION: BY LAW, IF CHILD/MINOR ABUSE IS LISTED/MENTIONED, THE LSU AGCENTER IS MANDATED TO REPORT TO DEPARTMENT OF CHILDREN AND FAMILY SERVICES.

SECTION 5: HEALTH INSURANCE

Covered _____ **Yes** _____ **No**

Company Name _____

Company Address _____

Policy Number _____

Group Number _____

Policy Holder Name _____

SECTION 7: DEVICES

Please indicate if you use any of the following. Explain any items and list any other problems, including diagnosis, date of injury or illness, hospital, length of hospitalization, name of doctor, etc.

List any Devices Required for participant (i.e. Epi-Pen, Inhaler, Crutches, Ear Plugs, etc.)

SECTION 6: CONDITIONS Is there past or present history of the following? Please indicate YES or NO on each.

	YES	**NO**
I understand that I must report any exposure to infectious disease that occurs within two weeks prior to the event date.		
ADHD		
Allergies/Sinus Concerns		
Appendicitis		
Arthritis or other similar condition		
Asthma/persistent cough		
Autism		
Back/Join or Limb Pain		
Bleeding/Clotting Disorder		
Bedwetting		
Eye/Ear Concerns		
Fainting/Blood Pressure Concerns		
Heart Concerns		
Hypoglycemia		
Insect Bites		
Menstrual Concerns		
Nervous condition/Depression		
Nose Bleeds/Nose Concerns		
Sleepwalking/Sleep Concerns		
Tuberculosis		
Ulcers (stomach/intestines)		
Urinary Concerns		
Kidney Concerns		
Liver Concerns		
Migraines		
Skin/Gland Concerns		
Stomach/Bowel Concerns		
Epilepsy, Convulsions or Seizures		
Diabetes		

**Localized redness/swelling do not constitute insect allergy. Body-wide rash, swelling, and difficulty breathing do constitute insect allergy (anaphylaxis).*

List any Other Conditions (i.e. physical disability, recent surgery, serious illness, serious injury) Does this individual have any other health-related conditions, including those requiring medication? If yes, please describe.

Explain any "Yes" items and list any other problems, including the diagnosis, date of injury or illness, hospital, length of hospitalization, name of doctor, etc. List any exposure to infectious disease in the two weeks prior to event.

(Attach a page if extra space is needed for explanation)

PARTICIPANT HEALTH AND MEDICAL HISTORY

SECTION 8: ALLERGIES

_____ **NO known allergies**

_____ **ALLERGIC to:**

- _____ **Foods** _____
- _____ **Medicines** _____
- _____ **Environment** _____

What is participant allergic to? (Specific)	What is the typical reaction seen?	What is treatment needed?

(Attach a page if extra space is needed for explanation)

SECTION 10: SPECIAL OR PRESCRIPTION MEDICATION

	NO	**This participant does not need to take any special or prescription medication while at this event/program.**
	YES	**This participant will need to take special or prescription medication while at this event.**

If YES, you must complete PAGE 4 in detail.

SECTION 11: CERTIFICATION OF HEALTH/MEDICAL RECORD

To my knowledge, this participant, has no health problems, unless stated earlier, and can **SAFELY PARTICIPATE** in this event.

FURTHERMORE, I, the undersigned, certify the participant for which is form is completed for has had no contagious or communicable disease and/or illness within the last 30 days that would preclude them from participating in this event/program. If any health problems or illnesses have occurred, they are explained in this form.

I understand that such administration of over-the-counter medication will be not done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed. Any condition which is associated with fever, significant inflammation and/or did not respond to the above outlined treatment, would be followed-up with a consultation with the camper's parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I understand that these OTC medications are not necessarily kept on hand and available to be administered immediately.

I authorize the administration of OTC medications to my child as indicated above. I shall indemnify and hold harmless the LSU AgCenter, its staff, and volunteers. LSU AgCenter's, its Board of Supervisors, Administration, Faculty, Staff, Volunteers, and all other officers, directors, employees and agents against any claims that may arise relating to my child being administered the above indicated OTC medications.

I/We have legal authority to consent to medical treatment for the camper named above, including the administration of medication at the above referenced Camp.

_____ _____

Signature of Parent/Guardian(s) or Adult Date

_____ _____

Primary Phone Number (Cell/Home) Work Phone Number

SECTION 9: OVER-THE-COUNTER (OTC) MEDICATION.

At times OTC medication(s) need to be administered, if approval is indicated by the 4-H member's parent or guardian. Please complete the following section if your child may need any of these OTC medications during his/her stay. NOTE: Unless we have parental authorization, we cannot administer ANY medications.

* = Not Provided at Camp Grant Walker	YES	NO
Acetaminophen (i.e. Tylenol)		
Antihistamine/Allergy Medication*		
Aloe Gel or Cream (for sunburn)		
Rolaids or Tums for acid reflux, heartburn or indigestion as directed*		
Diphenhydramine antihistamine/allergy medicine (i.e. Benadryl)		
Caladryl		
Calamine Lotion		
Cetirizine (Zyrtec)		
Guaifenesin Cough Syrup (i.e. Robitussin)*		
Pseudoephedrine Decongestant (i.e. Sudafed)*		
Dramamine		
Visine/Eye Drops (minor eye irritation)		
Ibuprofen (i.e. Motrin, Advil)		
Imodium or Kaopectate (for diarrhea)*		
Insect Repellent/Bug Spray*		
Medicated Lip Ointment for dry, chapped lips, lip blisters or canker sores as directed*		
Pepto Bismol, Milk of Magnesia or Mylanta (for upset stomach/ diarrhea)*		
Antibiotic Cream		
Sore Throat Spray/Lozenges		
Swimmers Ear Drops		
Sunscreen*		
Micatin or anti fungus treatment as direct for athlete's foot*		
Other (list any other approved over-the-counter drugs not previously listed):		

OVER-THE-COUNTER MEDICATION NOTE(S):

- **Staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above.**
- **OTC Medication may or may not be available at all 4-H events based on location, length of event, and/or other rules/guidelines.**

WHAT HAVE WE FORGOTTEN TO ASK?

Please attach an additional page with any information about the participant that you think is important or that may affect the participant's ability to fully participate.

LOUISIANA 4-H YOUTH DEVELOPMENT

2025-2026
PARENT/GUARDIAN AUTHORIZATION AND CONSENT FOR SPECIAL AND/OR PRESCRIPTION MEDICATION

TO: Louisiana 4-H Youth Development Program and/or representative

Please administer my child: _____ **(Child's name) the medication(s) listed below as order by**

Dr. _____ **(Name of Physician)** _____ **(Phone)**

I accept the rules of the Louisiana 4-H Youth Development concerning the giving of medication, including the following:

1. The Camp Nurse (4-H Camp), or authorized 4-H personnel, will administer medication.
2. All medication is given to the 4-H personnel by a parent or guardian before departure for an event.
3. All prescription medication is to be prescribed by a physician.
4. All prescription medication must be in the original container with a label from the pharmacy showing the name of the medication, dosage, date last filled (must not be expired or expire during the 4-H event), child's name, and how often to administer the medication.
5. All prescription and over-the-counter medication must be unopened in its original container when given to the parish 4-H agent. Each medication (prescription and over the counter) must include a signed Parent/Guardian Authorization and Consent Form and placed inside a Ziploc bag labeled with the child's name and parish..
6. We require that you send only the amount of medication needed for the duration of the 4-H Event. No extras. For convenience, we highly recommend using pharmacy blister packs.

Beginning in 2026, Lousiana 4-H strongly encourages that all prescription medication be provided in blister packs. Parents/Guardians can obtain blister packs from their local pharmacy. Louisiana 4-H will not accept blister packs from Amazon or other non-pharmacy sources. Over the counter medication may also be provided in blister packs from a pharmacy. Blister packs offer a safe, practical, and parent-friendly way to manage medication at camp.

Benefits of Blister Packs:

- **Organization**: Doses are clearly separated, making schedules easy to follow.
- **Accuracy**: Reduces the risk of missed or double doses.
- **Safety**: Ensures proper administration in group settings.
- **Convenience**: Compact and easy to transport.
- **Compliance**: Simplifies medication management for children and medical staff.
- **Reduced Waste**: Provides only the required doses, avoiding extras and confusion.

NAME OF MEDICATION (Brand or Generic Name)	DATE STARTED	REASON FOR TAKING IT	ESTIMATED TIME GIVEN/TAKEN	AMOUNT OR DOSE TO BE GIVEN	HOW IS IT GIVEN/TAKEN
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____		

If additional medications are needed, please complete a second form listing those medications.

I certify to the Louisiana Cooperative Extension Service and the 4-H Youth Development Program that it is necessary for my child to receive the above listed medication(s) during this 4-H activity/trip/experience.

_____ _____

Signature of Parent(s) or Guardian(s) Date

_____

Parent(s) or Guardian(s) Address, City, State, and Zip

_____ _____

Primary Phone Number (Cell/Home) Work Phone Number